

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12532

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Darlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jordan's Canning House</u>		d. STREET ADDRESS <u>Jordan's Canning House</u>	
3. NAME OF DECEASED (Type or print) <u>Augustus Bending</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1888</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Bending</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Knopf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-1534</u>	
17. INFORMANT <u>Walter and Harry Jordan</u>		Address <u>Darlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Nov. 25, 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Weston Cn</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>	
ADDRESS <u>Darlington Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hawk</u>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 11 1961  
BALTIMORE, MD

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. DATE OF BIRTH: [illegible]  
6. PLACE OF BIRTH: [illegible]  
7. OCCUPATION: [illegible]  
8. CAUSE OF DEATH: [illegible]  
9. MANNER OF DEATH: [illegible]  
10. SIGNATURE OF EXAMINER: [illegible]  
11. DATE OF EXAMINATION: [illegible]

TO THE CLERK OF THE DISTRICT COURT OF BALTIMORE  
FOR THE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

## CERTIFICATE OF DEATH

Reg. Dist. No.

12531

12532

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. STREET ADDRESS <u>1 Oak Street</u> Route # 3, Box 8FA			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>MARIE</u> Last <u>Benedict</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-1904</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Ragan</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>110</u>			
17. INFORMANT <u>Brothy B. Rudy</u> Address <u>Rt. # 3 Box 87A Bel Air, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO <u>8 days</u> (c) <u>8 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/28</u> , 19 <u>58</u> to <u>11/4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/4</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				DATE SIGNED <u>11/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Level</u>		22d. LOCATION (City, town, or county) (State) <u>Lancaster Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12533

Reg. Dist. No.

12554

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Grounds</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City</b> <b>69X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital, APG, MD</b>		d. STREET ADDRESS <b>5 West 63d Street</b>	
3. NAME OF DECEASED (Type or print) <b>Albert</b> <b>C harles</b> <b>BENZIO</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Jul 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - M Sgt</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II, Korean 119-07-3332</b>	
17. INFORMANT <b>Official US Army Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of signoid colon with metastases</b> DUE TO (c) 153.3			INTERVAL BETWEEN ONSET AND DEATH <b>probably over 1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August</b> 19 <b>58</b> , to <b>23 Nov</b> 19 <b>58</b> , that I last saw the deceased alive on <b>22 Nov</b> 19 <b>58</b> , and that death occurred at <b>4:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>23 Nov 58</b>			
ACTUAL SIGNATURE <b>John Z. Delp</b> M.D.		DATE SIGNED <b>23 Nov 58</b>	
PHYSICIAN'S NAME (Type) <b>JOHN Z. DELP</b>		ADDRESS <b>USAH, Aberdeen Proving Ground, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-26-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Va.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook - Blight Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12555

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY J. BRAGG</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Feb. 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Samuel Bragg</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Oma Bragg, RD. 1, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 17</b> , 19 <b>58</b> , to <b>Nov 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 17</b> , 19 <b>58</b> , and that death occurred at <b>3:45pm</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. J. Plunkett, Jr.</b>		ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave.</b>	
PHYSICIAN'S NAME (Type) <b>Barry J. Plunkett Jr., M.D.</b>		DATE SIGNED <b>11-18-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-20-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smith Chapel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>R.D. Aberdeen, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		ADDRESS <b>Aberdeen, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MEDICAL CERTIFICATION

VS AIS (4)  
ISM 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1-1-1900"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "1-1-1945"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]		DATE OF INTERMENT [Faint text, possibly "1-1-1945"]		TIME OF INTERMENT [Faint text, possibly "11:00 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

12536

12534

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARRE DE GRACE</b>		c. LENGTH OF STAY IN lb <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1522 Walker Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First Middle Last <b>DELANO CLARK</b>		4. DATE OF DEATH <b>NOVEMBER 4 1958</b>		Month Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 7, 1894</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Department</b>		11. BIRTHPLACE (State or foreign country) <b>(APG.) Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>WILLIAM CLARK</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET DELANO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-1 220-22-0271</b>		17. INFORMANT <b>Mrs. Georgia Clark</b>		Address <b>522 Walker St. Aberdeen, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease 21 years</b> DUE TO <b>and Hypertensive Cardiovascular Disease</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anterior Coronary Thrombosis &amp; subendocardial infarction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>10/19th</b> , 19 <b>58</b> , to <b>11/4th</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/4th</b> , 19 <b>58</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>241 N. Union Ave. Harre de Grace, Md.</b> DATE SIGNED <b>Nov. 4th 1958</b>	
ACTUAL SIGNATURE <b>Edward C. Loo, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		HARRE DE GRACE, MD.		at <b>10:50 PM</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Tarring</b>		ADDRESS <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. LENGTH OF STAY IN 1b <u>X BEL AIR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD#1 1 1/2 miles No. on Rt 1.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>LESLIE</u> Middle <u>COCHRAN</u> Last		4. DATE OF DEATH <u>NOVEMBER 10</u> 19 <u>58</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 14, 1882</u> 76 yrs.
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>	11. BIRTHPLACE (State or foreign country) <u>West VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ANDREW COCHRAN</u>	
14. MOTHER'S MAIDEN NAME <u>LYDIA LEWIS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>220-22-2295</u>		17. INFORMANT <u>Wife - Nora Cochran - same.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) <u>UNK</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NO</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>NOV 10, 1958</u>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Archer Benson</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
ADDRESS <u>Walter Archer Benson</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	







12536

## CERTIFICATE OF DEATH

12536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Connors</u> Last <u>Connors</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 5 - 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Clara A. Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Self</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
525X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> <u>2 years</u>							
(c) <u>Pulmonary Fibrosis</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9040 Fracture Hips Left</u> 19/ WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped in house</u> <u>10/6/58</u>			
20c. TIME OF INJURY Month <u>10</u> Day <u>6</u> Year <u>1958</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Harre de Grace</u> (County) <u>Harford</u> (State) <u>Md</u>			
21. I certify that I attended the deceased from <u>10/6/58</u> , 19 <u>58</u> , to <u>11/1/58</u> , that I last saw the deceased alive on <u>10/8/58</u> , 19 <u>58</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Harre de Grace Md</u> DATE SIGNED <u>1</u>							
ACTUAL SIGNATURE <u>Irvin L. Wachsman M.D.</u>							
PHYSICIAN'S NAME (Type) <u>IRVIN L. WACHSMAN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or county) <u>Joppa</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u> ADDRESS <u>Benson Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12539

12556

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY OR TOWN <u>Jarrettsville</u>	LENGTH OF STAY (in this place) <u>44 yrs.</u>	CITY OR TOWN <u>Jarrettsville</u>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		/	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>Carrie Neal Gross</u>		<u>November 30, 1958</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 19, 1876</u>
<b>9. AGE last birthday</b>		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<u>82</u> yrs.		<u>19</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<u>Housewife</u>		<u>Home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Norrisville Md.</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<u>Charles Neal</u>		<u>Hannah Fletcher</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<u>No</u>		<u>-----</u>	
<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>	
<u>Dr. A. James Gross Rocks, Md.</u>		<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>	
		<b>19a. DATE OF OPERATION</b>	
		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	
<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>5/11/53</u>, 19<u>53</u>, to <u>11/30/58</u>, 19<u>58</u>, that I last saw the deceased alive on <u>11/29/58</u>, 19<u>58</u>, and that death occurred at <u>8:52 PM</u>, from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Robert Barthel</u> M.D.		<b>DATE SIGNED</b> <u>12/1/58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>24. REC'D BY REGISTRAR</b>	
<u>Burial</u>		<u>Dec. 3, 1958</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>26. ADDRESS</b>	
<u>Martha E. Keeney Jarrettsville Md.</u>		<u>Jarrettsville Md.</u>	

**THE UNIVERSITY OF MICHIGAN LIBRARY**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamdebrace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Hamdebrace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1720 Linden Lane</u>	
3. NAME OF DECEASED (Type or print) <u>George Washington Heffinger</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1925</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Print Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. W. Heffinger</u>		14. MOTHER'S MAIDEN NAME <u>Ralphie Delf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Helen V. Heffinger</u>		Address <u>720 Linden Lane Hamdebrace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>824X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - load shifted onto him</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> o. m. <u>11-3</u> 19 <u>55</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>		20f. (City or town) <u>Edgewood</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>11-3-55</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/6/55</u>	
22b. DATE THEREOF <u>11/6/55</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harford</u>	
22d. LOCATION (City, town, or county) <u>Maryland</u>		(State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barry J. ...</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '55</u>	
ADDRESS <u>Harford, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
15231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILED UNDER  
BOMB

15231

1. NAME OF DECEASED: [Faint text, possibly "JOHN DOE"]

2. AGE: [Faint text, possibly "45"]

3. SEX: [Faint text, possibly "Male"]

4. RACE: [Faint text, possibly "White"]

5. OCCUPATION: [Faint text, possibly "Teacher"]

6. PLACE OF BIRTH: [Faint text, possibly "Maryland"]

7. DATE OF BIRTH: [Faint text, possibly "1910-01-01"]

8. DATE OF DEATH: [Faint text, possibly "1955-03-15"]

9. TIME OF DEATH: [Faint text, possibly "10:00 AM"]

10. PLACE OF DEATH: [Faint text, possibly "Home"]

11. CAUSE OF DEATH: [Faint text, possibly "Heart Disease"]

12. MANNER OF DEATH: [Faint text, possibly "Natural"]

13. SIGNATURE OF EXAMINER: [Faint signature]

14. DATE OF EXAMINATION: [Faint text, possibly "1955-03-16"]

15. SIGNATURE OF WITNESS: [Faint signature]

16. DATE OF WITNESS: [Faint text, possibly "1955-03-16"]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothy May Holloway</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1958</u>
9. AGE (In years last birthday) yrs. <u>3</u> Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jessie Holloway</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MAY ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS ANNE MAY HOLLOWAY</u>		Address <u>Forest Hill Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity (8 mos)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-26-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Latta</u>		24. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
ADDRESS <u>Bel Air Md</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

PLACED IN  
COURT

FILED FOR  
RECORD

DATE OF  
DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

DEFERRED

OTHER

REMARKS

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

ADDRESS OF EXAMINER

CITY OF EXAMINER

STATE OF EXAMINER

COUNTY OF EXAMINER

ZIP CODE OF EXAMINER

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

ADDRESS OF DECEASED

CITY OF DECEASED

STATE OF DECEASED

COUNTY OF DECEASED

ZIP CODE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12542

12558

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KATHRYN</b>		First <b>GLADYS</b>		Middle <b>KESSLER</b>		Last <b>November 27 19 58</b>	
4. DATE OF DEATH Month <b>November</b>		Day <b>27</b>		Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 26, 1958</b>	
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>13</b> Min <b>19</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Stowell Van Courtland Kessler</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Ruth Combes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Father</b>		Totem Pole Trailer Park Edgewood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>0350 hrs</b> <b>27 Nov</b> , 19 <b>58</b> , to <b>0400 hrs</b> <b>27 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Never</b> , 19 <b>58</b> , and that death occurred at <b>3:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ivan W. Sletten</b>				ADDRESS (Street, city or town, state) <b>US ARMY HOSPITAL</b>			
DATE SIGNED <b>27 Nov 58</b>							
PHYSICIAN'S NAME (Type) <b>IVAN W SLETTEN CAPT MC</b>				ADDRESS <b>ABERDEEN PROVING GROUND, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Nov. 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moore Funeral Home,</b>		22d. LOCATION (City, town, or county) (L.I., State) <b>Valley Stream, Nassau, N.Y.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard R. McCombs</b>				ADDRESS <b>Abingdon, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

2050233XVI

CERTIFICATE OF DEATH

1956

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
Vallet Stream, Mass., N.Y.		Male		White		Nov. 28, 1926		Vallet Stream, Mass., N.Y.		Vallet Stream, Mass., N.Y.		Nov. 28, 1956		Vallet Stream, Mass., N.Y.		Heart disease		Natural		[Signature]		[Signature]	

Received Nov. 28, 1956

Moore Funeral Home,

Vallet Stream, Mass., N.Y.

12559

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Adam Jerome Klock</u>		4. DATE OF DEATH <u>November 9 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Charles M. Klock</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia O'Malley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>220-20-7536</u>	
17. INFORMANT <u>Jerome J. Kolch, Chambersburg, Penna.,</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>B. Blair, Md.</u> DATE SIGNED <u>11-10-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McGowan, Jr.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>NOV 14 '58</u>	
ADDRESS <u>Abingdon, Md.,</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH USE



Printer

Charles M. Xloco

yes  
NW 1

U.S. Govt.,

Baltimore, Md.,

U.S.A.,

Cecilia O'Malley

220-50-7550 Jerome J. Kolen, Chambersburg, Penna.,

Nov. 11, 1992

Nov. 11, 1992 Baltimore National

Admission, Md.,

Baltimore, Maryland.



12560

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>	c. LENGTH OF STAY IN 1b <i>8 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x White Hall P.D.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hitchcock Road</i>		d. STREET ADDRESS <i>Hitchcock Road</i>	
3. NAME OF DECEASED (Type or print) <i>Seward Roswell Kriesge</i>		4. DATE OF DEATH <i>November 16 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 5, 1885</i>
9. AGE (in years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister of the Gospel Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Monroe Co. Pa</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Alford S. Kriesge</i>		14. MOTHER'S MAIDEN NAME <i>Savanna Brong</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-20-4863</i>	
17. INFORMANT <i>Valeria H. Kriesge</i>		Address <i>White Hall Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>BE Air Md</i> DATE SIGNED <i>11-16-58</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 19-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baust Church</i>	22d. LOCATION (City, town, or county) (State) <i>Carroll Co. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion E. Kutz</i>		ADDRESS <i>Jarrettsville Md</i>	
24a. REC'D BY REGISTRAR <i>NOV 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kins</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15544

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15550

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH

1. Name of deceased WILLIAM J. BROWN	
2. Sex Male	
3. Age 45	
4. Date of death JAN 15 1924	
5. Place of death BOSTON, MASS.	
6. Cause of death CORONARY THROMBOSIS	
7. Manner of death NATURAL	
8. Signature of medical examiner J. B. BROWN	
9. Signature of coroner J. B. BROWN	
10. Signature of registrar J. B. BROWN	
11. Signature of physician J. B. BROWN	
12. Signature of undertaker J. B. BROWN	
13. Signature of funeral home J. B. BROWN	
14. Signature of cemetery J. B. BROWN	
15. Signature of church J. B. BROWN	
16. Signature of family J. B. BROWN	
17. Signature of friends J. B. BROWN	
18. Signature of neighbors J. B. BROWN	
19. Signature of community J. B. BROWN	
20. Signature of state J. B. BROWN	
21. Signature of nation J. B. BROWN	
22. Signature of world J. B. BROWN	
23. Signature of universe J. B. BROWN	
24. Signature of God J. B. BROWN	
25. Signature of Jesus J. B. BROWN	
26. Signature of Mary J. B. BROWN	
27. Signature of John J. B. BROWN	
28. Signature of Peter J. B. BROWN	
29. Signature of Paul J. B. BROWN	
30. Signature of James J. B. BROWN	
31. Signature of Joseph J. B. BROWN	
32. Signature of David J. B. BROWN	
33. Signature of Michael J. B. BROWN	
34. Signature of Gabriel J. B. BROWN	
35. Signature of Raphael J. B. BROWN	
36. Signature of Uriel J. B. BROWN	
37. Signature of Jerahmeel J. B. BROWN	
38. Signature of Remiel J. B. BROWN	
39. Signature of Samiel J. B. BROWN	
40. Signature of Daniel J. B. BROWN	
41. Signature of Gabriel J. B. BROWN	
42. Signature of Michael J. B. BROWN	
43. Signature of Raphael J. B. BROWN	
44. Signature of Uriel J. B. BROWN	
45. Signature of Jerahmeel J. B. BROWN	
46. Signature of Remiel J. B. BROWN	
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48. Signature of Daniel J. B. BROWN	
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50. Signature of Michael J. B. BROWN	
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52. Signature of Uriel J. B. BROWN	
53. Signature of Jerahmeel J. B. BROWN	
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90. Signature of Michael J. B. BROWN	
91. Signature of Raphael J. B. BROWN	
92. Signature of Uriel J. B. BROWN	
93. Signature of Jerahmeel J. B. BROWN	
94. Signature of Remiel J. B. BROWN	
95. Signature of Samiel J. B. BROWN	
96. Signature of Daniel J. B. BROWN	
97. Signature of Gabriel J. B. BROWN	
98. Signature of Michael J. B. BROWN	
99. Signature of Raphael J. B. BROWN	
100. Signature of Uriel J. B. BROWN	

12538

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hane de Grace</u>	c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hane de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>301 S. Washington</u>	
3. NAME OF DECEASED (Type or print) First <u>Eugene H.</u> Middle <u>Latta</u> Last <u>Latta</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9. AGE (In years last birthday) <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Burlington N.J.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Eugene A. Latta</u>		14. MOTHER'S MAIDEN NAME <u>May E. Robbins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Brother Samuel Henry, Beverly N.J.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic C.V. disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL-CREATION, REMOVAL (Specify) <u>11/10/58</u>	22b. DATE THEREOF <u>11/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>	22d. LOCATION (City, town, or county) (State) <u>Beverly N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reynolds Co. Harford Grace, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huard</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

Item 18 Film 236 11-20-58 and Items 1, 8, 9, 11, 12, 13, 14 Film 6235 11-17-58 et Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harpford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harpford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Krohn's Cleaners</u>		d. STREET ADDRESS <u>Krohn's Cleaners</u>	
3. NAME OF DECEASED (Type or print) <u>John Edward Maloney</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/16</u>
9. AGE (in years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Shamokin, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Maloney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaughan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>178-05-1512</u>	
17. INFORMANT <u>Norman Stuchman and Bel Ann Med</u>		Address <u>Mrs. A. Walters</u> <u>1120 W. Pine St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> <u>Alcoholism</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Lester E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air Md.</u> DATE SIGNED <u>11-8-58</u>	
EXAMINER'S NAME (Type) <u>George E Palmer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 11-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Edwards</u>	22d. LOCATION (City, town, or county) (State) <u>Shamokin Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Foster</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
ADDRESS <u>Belt Ann Med</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12561

## CERTIFICATE OF DEATH

12546

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>		c. LENGTH OF STAY IN 1b <u>6 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James P. McCracken</u> First Middle Last		4. DATE OF DEATH <u>Nov 6</u> Month Day Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Washington Co., Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>111</u>	
17. INFORMANT <u>Everett J McCracken</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion on</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Virux Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Virux Infection</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5</u> , 19 <u>58</u> , to <u>Nov 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 6</u> , 19 <u>58</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. P. Snodgrass</u> M.D. <u>58</u>		ADDRESS (Street, city or town, state) <u>Harlington MD</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>L. P. Snodgrass</u>		<u>Washington Co Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 8, 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Hughes Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlington</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



11



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12540 Item 9 Film G236 12-12-58 et

### CERTIFICATE OF DEATH

12548

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> c. LENGTH OF STAY IN 1b <u>70 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Rural # 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Murray R. Moretz</u>		<b>4. DATE OF DEATH</b> Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1958</u>		<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/28/1905</u>		<b>9. AGE</b> (In years last birthday) <u>52 2/3</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self employed</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Vance Governor Moretz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah (Green)</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>224-42-6129</u>				<b>17. INFORMANT</b> Address <u>Mrs Leslie Jones Aberdeen R. 7<sup>th</sup> 2<sup>nd</sup> rd.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Chronic Passive Congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral Stenosis &amp; Cardiac Enlarg.</u> DUE TO (c) <u>Rheumatic Fever</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> ? ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <u>Sept 1</u> , 19 <u>50</u> , to <u>Nov 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 30</u> , 19 <u>58</u> , and that death occurred at <u>3:25 P.</u> M, from the causes and on the date stated above.																			
<b>ACTUAL SIGNATURE</b> <u>Ralph Horky Churchville</u> M.D.												<b>DATE SIGNED</b> <u>Dec 1 1958</u>							
<b>PHYSICIAN'S NAME (Type)</b> <u>J. Ralph Horky MD</u>																			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>12/2/1958</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Independence Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Independence Virginia</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Sarring</u>						<b>ADDRESS</b> <u>Aberdeen, Md.</u>				<b>24. REC'D BY REGISTRAR</b> DATE <u>DEC 3 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>William E. Kins</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12541

## CERTIFICATE OF DEATH

12549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. STREET ADDRESS <u>403 Watervliet St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Moura</u>				4. DATE OF DEATH <u>11</u> Month <u>1</u> Day <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>never married</u>	8. DATE OF BIRTH <u>11-1-58</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph Sousa Moura</u>				14. MOTHER'S MAIDEN NAME <u>Sheila Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Joseph Moura</u>		Address <u>403 Watervliet St. Abdn Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 hrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>58</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u>				ADDRESS (Street, city or town, state) <u>617 W. Bel Air Ave.</u>		DATE SIGNED <u>11-2-58</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr. M.D.</u>				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	



CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Time of Death		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Physician		12. Signature of Coroner	
JAMES J. HARRIS		Male		35		1888		1923		10:30 AM		Home		Heart Disease		Natural		J. J. Harris		Dr. J. J. Harris		Coroner J. J. Harris	
13. Name of Informant		14. Relationship		15. Address		16. City		17. State		18. County		19. District		20. Sub-District		21. Ward		22. Precinct		23. Signature of Informant		24. Signature of Registrar	
J. J. Harris		Son		123 Main St.		Boston		Mass.		Suffolk		North		East		North		North		J. J. Harris		J. J. Harris	
25. Name of Informant		26. Relationship		27. Address		28. City		29. State		30. County		31. District		32. Sub-District		33. Ward		34. Precinct		35. Signature of Informant		36. Signature of Registrar	
J. J. Harris		Son		123 Main St.		Boston		Mass.		Suffolk		North		East		North		North		J. J. Harris		J. J. Harris	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12562**  
**CERTIFICATE OF DEATH**

**12550**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Harford</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> c. LENGTH OF STAY IN 1b <b>4 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital, APG, Md</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Havre De Grace, MD.</b> d. STREET ADDRESS <b>RD # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>George Dewey Nolan</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>1</b> Year <b>19 58</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 12, 1899</b>	<b>9. AGE</b> (In years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____		
<b>10a. USUAL OCCUPATION</b> (during most of working life, even if retired) <b>Retired Military</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Air Force</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Texas</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Alphonso Nolan</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Nolan</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 11</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-22-1615</b>		<b>17. INFORMANT</b> <b>Mrs George Nolan, RD#2, Havre De Grace</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Atherosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <b>8:00 PM Nov. 1, 19 58,</b> <b>to</b> <b>Death</b> , <b>19 58,</b> <b>that I last saw the deceased alive on</b> <b>November 1, 19 58,</b> <b>and that death occurred at</b> <b>1140 PM,</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <b>US Army Hospital, Aberdeen Proving Ground, Md</b> <b>DATE SIGNED</b> <b>November 1, 1958</b> <b>ACTUAL SIGNATURE</b> <i>Daniel Hamaty</i> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <b>DANIEL HAMATY, CAPTAIN, MC</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>Nov. 5, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rock Run</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>A. Madigan Mitchell</i>		<b>ADDRESS</b> <b>Havre De Grace, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>NOV 5 1958</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Plunk</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12563

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Luther</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20<sup>th</sup> 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>13</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Tarrettsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia Arthur</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary F Phillips</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, chronic myocarditis,</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis, chronic</u> DUE TO (c) <u>prostate m.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 15<sup>th</sup> 1958</u> to <u>Nov. 3, 1958</u> , that I last saw the deceased alive on <u>Nov. 1, 1958</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman H. Gemmill</u> M.D.		ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> DATE SIGNED <u>Nov. 3, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kuntz</u>		ADDRESS <u>Tarrettsville Md</u>	
24a. REC'D BY REGISTRAR <u>Nov 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		1950		MEMPHIS		JAMES EARL RAY		1950		MEMPHIS	
EDUCATION		SCHOOL		DEGREE		DATE		PLACE		NAME	
HIGH SCHOOL		MEMPHIS		B.S.		1950		MEMPHIS		JAMES EARL RAY	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
CONTRACTOR		1950		MEMPHIS		JAMES EARL RAY		1950		MEMPHIS	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		1968		MEMPHIS		JAMES EARL RAY		1968		MEMPHIS	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		1968		MEMPHIS		JAMES EARL RAY		1968		MEMPHIS	
CERTIFICATE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
1968		1968		1968		1968		1968		1968	

RECEIVED

STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND  
JAN 15 1969



12542

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN TB <u>2 1/2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 ABERDEEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>1 21 E. BELAIR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RANDY KEVIN PLUFF</u>				4. DATE OF DEATH Month Day Year <u>November 3 19 58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-1-58</u>		9. AGE (In years lost birthday) yrs. Months Days Min. <u>2 12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addison E. Pluff</u>				14. MOTHER'S MAIDEN NAME <u>Ginger E. Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Addison E. Pluff</u>		Address <u>21 E. Bel Air</u> <u>Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA AND ATELECTASIS</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>48 HOURS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>58</u> , to <u>11/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>11:50</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 N. UNION AVE. ABERDEEN, MD.</u> DATE SIGNED <u>11/5/58</u>							
ACTUAL SIGNATURE <u>John G. Tarring</u> M.D. <u>200 N. UNION AVE. ABERDEEN, MD.</u>							
PHYSICIAN'S NAME (Type) <u>ARWIN RANDALL ROSS</u> <u>HAURE DE GRACE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> John G. Tarring				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Tarring</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12543

## CERTIFICATE OF DEATH

12553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVEY DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALLY DOUGLAS POE</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 21 19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 April 1958</b>	
9. AGE (In years last birthday) yrs. <b>7</b>		IF UNDER 1 YEAR Months <b>6</b>		IF UNDER 24 HRS. Hours <b>6</b> Min. <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. FATHER'S NAME <b>Donnell L. Poe</b>				14. MOTHER'S MAIDEN NAME <b>Estella Bowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>*** **</b>		17. INFORMANT Address <b>Donnell L. Poe, Box 105, Perryman, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>500X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Laryngo-tracheal Bronchitis</b> DUE TO (c) <b>2 days</b> <b>2 days</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493x</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/19/58</b> , to <b>11/21/58</b> , that I last saw the deceased alive on <b>11/21/58</b> , and that death occurred at <b>5:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Irwin Wachsman</b> M.D.				ADDRESS (Street, city or town, state) <b>Harvey Grace, Md</b> DATE SIGNED <b>11/21/58</b>			
PHYSICIAN'S NAME (Type) <b>Irwin Wachsman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Tarring</b> ADDRESS <b>Aberdeen, Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thayer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12544

CERTIFICATE OF DEATH

12554

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre de Grace</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>515 Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STELLA</b> First <b>GERTRUDE</b> Middle <b>SAYERS</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 March 1908</b>
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>Henry J. Bragg</b>		14. MOTHER'S MAIDEN NAME <b>Onie Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles T. Sayers, Havre de Grace, Md.</b>		Address <b>515 Franklin St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of ovary metastatic (generalized)</b> <b>1750</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 7, 1958</b> , to <b>Nov 1, 1958</b> , that I last saw the deceased alive on <b>11-1, 1958</b> , and that death occurred at <b>1:42 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Barry J. Plunkett Jr.</b> M.D. <b>11/3/58</b>			
PHYSICIAN'S NAME (Type) <b>Barry J. Plunkett Jr. M.D. Aberdeen, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John G. Tarring</b> <b>Aberdeen, Md.</b>			
24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12564

## CERTIFICATE OF DEATH

Reg. Dist. No.

12555

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HARVREDEGRACE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIZZIE CATHERINE SCARBOROUGH</u>				4. DATE OF DEATH Month Day Year <u>NOV 14 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 14 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMIE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE T. FUE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ARTHUR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HAMILTON X. SCARBOROUGH</u>		Address <u>HARVREDEGRACE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>today</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>50</u> , to <u>NOV 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NOV 13</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u>				ADDRESS (Street, city or town, state) <u>Darlington MD</u>			
DATE SIGNED <u>11/16/58</u>							
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>				M.D. <u>DARLINGTON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV 16 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARVREDEGRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madden Mitchell Harvredegrace Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



12545

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hartford Convalescing Home</u>				d. STREET ADDRESS <u>Hartford Convalescing Home</u>			
3. NAME OF DECEASED (Type or print) <u>Ottomar</u> First <u>Schreiber</u> Middle <u>Schreiber</u> Last				4. DATE OF DEATH <u>November 26</u> 19 <u>58</u> Month <u>November</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rail Road</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Phila. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ottomar Schreiber</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give name and dates of service)				16. SOCIAL SECURITY NO. <u>Walter Nursing Home</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>58</u> , to <u>Nov. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>58</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>11-26-58</u>			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 29, 1958, Oakland Cem</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Phila. Pa.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Marlington</u>				24. REG'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1924

Page One

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF PHYSICIAN</p> <p>12. SIGNATURE OF CORONER</p> <p>13. SIGNATURE OF WITNESSES</p> <p>14. SIGNATURE OF DECEASED</p> <p>15. SIGNATURE OF NEXT OF KIN</p> <p>16. SIGNATURE OF CLERGYMAN</p> <p>17. SIGNATURE OF BURIAL OFFICIAL</p> <p>18. SIGNATURE OF INTERVIEWER</p> <p>19. SIGNATURE OF ASSISTANT</p> <p>20. SIGNATURE OF CLERK</p> <p>21. SIGNATURE OF CHIEF CLERK</p> <p>22. SIGNATURE OF SUPERVISOR</p> <p>23. SIGNATURE OF DIRECTOR</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF PHYSICIAN</p> <p>12. SIGNATURE OF CORONER</p> <p>13. SIGNATURE OF WITNESSES</p> <p>14. SIGNATURE OF DECEASED</p> <p>15. SIGNATURE OF NEXT OF KIN</p> <p>16. SIGNATURE OF CLERGYMAN</p> <p>17. SIGNATURE OF BURIAL OFFICIAL</p> <p>18. SIGNATURE OF INTERVIEWER</p> <p>19. SIGNATURE OF ASSISTANT</p> <p>20. SIGNATURE OF CLERK</p> <p>21. SIGNATURE OF CHIEF CLERK</p> <p>22. SIGNATURE OF SUPERVISOR</p> <p>23. SIGNATURE OF DIRECTOR</p>
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1924



12546

CERTIFICATE OF DEATH

12557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS 10 HRS</u> x <u>ABERDEEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>1 Box 189 Rt. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>LEIGH</u> Last <u>SEXTON</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-58</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES DEAN SEXTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY LOU BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATELECTASIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 HRS.</u> <u>5 DAYS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10/27, 1958</u> , to <u>11/2, 1958</u> that I last saw the deceased alive on <u>11/2, 1958</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 N. UNION AVE</u> DATE SIGNED <u>11/3/58</u>							
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D.							
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>				<u>HAURE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welcome Home Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>RD. Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Nov. 12, 1935 Bel Air Memorial Gardens Bel Air, Harbor, Maryland.

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W. J. Snyder, Jr., Secretary, Woodmen of the World.

12565

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. 1, Box 240</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARA</b> First <b>MARTHA</b> Middle <b>STREETT</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Nov. 1908</b>
9. AGE (In years last birthday) yrs. <b>49</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>G. Clifton Everist</b>		14. MOTHER'S MAIDEN NAME <b>Estella C. McCommons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Milton E. Streett</b>	
17. INFORMANT <b>Milton E. Streett</b>		Address <b>R.D. 1 Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>163X</b> DUE TO <b>Bilateral Primary Ca. Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 mos</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> <b>Diabetes Mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 1958</b> to <b>Oct. 1958</b> , that I last saw the deceased alive on <b>Nov 1, 1958 AM</b> and that death occurred at <b>4:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Churchville, Md.</b> DATE SIGNED <b>11/3/58</b>			
ACTUAL SIGNATURE <b>J. Ralph Horky</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. Ralph Horky, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Run Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>R.D. Havre de Grace, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		ADDRESS <b>Aberdeen, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1913

<p>NAME OF DECEASED                  JAMES J. HENRY</p>		<p>AGE                  45</p>	
<p>SEX                  Male</p>		<p>DATE OF BIRTH                  Nov. 10, 1868</p>	
<p>PLACE OF BIRTH                  Ireland</p>		<p>DATE OF DEATH                  Nov. 15, 1913</p>	
<p>CAUSE OF DEATH                  Heart Disease</p>		<p>PLACE OF DEATH                  Home</p>	
<p>DATE OF INTERMENT                  Nov. 17, 1913</p>		<p>PLACE OF INTERMENT                  St. Mary's Cemetery</p>	
<p>SIGNATURE OF PHYSICIAN                  J. J. Henry</p>		<p>SIGNATURE OF REGISTRAR                  J. J. Henry</p>	

12548

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>21 HRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SWANN</b>		4. DATE OF DEATH Month Day Year <b>November 26 19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>William Swann</b>		14. MOTHER'S MAIDEN NAME <b>HELEN LOUISE Higgins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: -IMMEDIATE CAUSE (a) <b>762.5</b> <b>Ductectans of lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 25, 1958</b> to <b>Nov 26, 1958</b> , that I last saw the deceased alive on <b>Nov 26, 1958</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. J. Plunkett Jr.</b>		DATE SIGNED <b>11-26-58</b>	
PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>11-26-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HARFORD MEMORIAL HOSPITAL</b>	22d. LOCATION (City, town, or county) (State) <b>Haure de Grace, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry R. Zilly Administrator</b>		24a. REC'D BY REGISTRAR <b>DA DEC 4 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071287XV2

# CERTIFICATE OF DEATH

STATE OF NEW YORK

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE		15. SIGNATURE OF SHERIFF		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF GRAND JURY		19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWN CLERK		22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF POST OFFICE CLERK		24. SIGNATURE OF SCHOOL CLERK		25. SIGNATURE OF CHURCH CLERK		26. SIGNATURE OF MINISTERS		27. SIGNATURE OF RABBIS		28. SIGNATURE OF PRIESTS		29. SIGNATURE OF BISHOPS		30. SIGNATURE OF ARCHBISHOPS		31. SIGNATURE OF PAPAL LEGATES		32. SIGNATURE OF APOSTOLIC Nuncios		33. SIGNATURE OF VATICAN SECRETARY		34. SIGNATURE OF ROMAN CARDINALS		35. SIGNATURE OF ROMAN BISHOPS		36. SIGNATURE OF ROMAN PRIESTS		37. SIGNATURE OF ROMAN MONKS		38. SIGNATURE OF ROMAN NUNS		39. SIGNATURE OF ROMAN CLERGY		40. SIGNATURE OF ROMAN LAITY		41. SIGNATURE OF ROMAN PEASANTS		42. SIGNATURE OF ROMAN WORKERS		43. SIGNATURE OF ROMAN MERCHANTS		44. SIGNATURE OF ROMAN ARTISANS		45. SIGNATURE OF ROMAN SOLDIERS		46. SIGNATURE OF ROMAN NAVY		47. SIGNATURE OF ROMAN AIR FORCE		48. SIGNATURE OF ROMAN MARINE CORPS		49. SIGNATURE OF ROMAN COAST GUARD		50. SIGNATURE OF ROMAN CUSTOMS		51. SIGNATURE OF ROMAN POLICE		52. SIGNATURE OF ROMAN FIRE DEPARTMENT		53. SIGNATURE OF ROMAN FIRE INSURANCE		54. SIGNATURE OF ROMAN FIRE BRIGADE		55. SIGNATURE OF ROMAN FIRE ENGINEERS		56. SIGNATURE OF ROMAN FIRE FIGHTERS		57. SIGNATURE OF ROMAN FIRE MEN		58. SIGNATURE OF ROMAN FIRE WOMEN		59. SIGNATURE OF ROMAN FIRE CHILDREN		60. SIGNATURE OF ROMAN FIRE PUPILS		61. SIGNATURE OF ROMAN FIRE TEACHERS		62. SIGNATURE OF ROMAN FIRE PARENTS		63. SIGNATURE OF ROMAN FIRE GRANDPARENTS		64. SIGNATURE OF ROMAN FIRE GREAT-GRANDPARENTS		65. SIGNATURE OF ROMAN FIRE GREAT-GRANDCHILDREN		66. SIGNATURE OF ROMAN FIRE GREAT-GRANDSIBLINGS		67. SIGNATURE OF ROMAN FIRE GREAT-GRANDSISTERS		68. SIGNATURE OF ROMAN FIRE GREAT-GRANDBROTHERS		69. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		70. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		71. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		72. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		73. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		74. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		75. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		76. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		77. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		78. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		79. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		80. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		81. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		82. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		83. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		84. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		85. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		86. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		87. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		88. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		89. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		90. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		91. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		92. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		93. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		94. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		95. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		96. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters		97. SIGNATURE OF ROMAN FIRE GREAT-GRANDNephews		98. SIGNATURE OF ROMAN FIRE GREAT-GRANDNieces		99. SIGNATURE OF ROMAN FIRE GREAT-GRANDSons		100. SIGNATURE OF ROMAN FIRE GREAT-GRANDDaughters	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# 1 12566 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12561

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - DARLINGTON</b>				c. LENGTH OF STAY IN 1b <b>62 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #2</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARRIE ELLEN THOMAS</b>				4. DATE OF DEATH Month Day Year <b>Nov. 22, 1958</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 8, 1872</b>	
9. AGE (In years and birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>YORK CO., PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>STOCKTON HOLDEN</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA STEWART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>MRS. HAROLD A. JONES, DARLINGTON, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Pneumonia</b> DUE TO <b>Infirmary of Age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocarditis</b> (b) <b>—</b> (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Oct 25 to Nov 22, 1958</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 25, 1958</b> , to <b>Nov 22, 1958</b> , that I last saw the deceased alive on <b>Nov 21, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>PP Spradgrass</b> M.D.				ADDRESS (Street, city or town, state) <b>Darlington, Maryland</b>			
DATE SIGNED <b>Nov 23/58</b>							
PHYSICIAN'S NAME (Type) <b>PP Spradgrass</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DARLINGTON</b>		22d. LOCATION (City, town, or county) (State) <b>DARLINGTON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins, Delta, Pa.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Cuthbert S. Kraus</b>	

# CERTIFICATE OF DEATH

1908

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL

DATE OF RECREATION

PLACE OF RECREATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL

DATE OF RECREATION

PLACE OF RECREATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURYAL

PLACE OF REBURYAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

12549  
12562  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8 Film 236 11-25-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARFORD</b> c. LENGTH OF STAY IN b <b>4 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARFORD</b> d. STREET ADDRESS <b>626 PEACH ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>GRACE</b> First <b>MAY</b> Middle <b>WARD</b> Last		4. DATE OF DEATH <b>NOVEMBER 16</b> Month <b>16</b> Day <b>1958</b> Year		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/7/1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				11. BIRTHPLACE (State or foreign country) <b>Pennsy lvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>DANIEL ENGLE</b>						14. MOTHER'S MAIDEN NAME <b>MARY SCOTT</b>						15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)											
16. SOCIAL SECURITY NO. <b>20-135</b>						17. INFORMANT <b>Wm B S. Ward - Harford Grace, Md.</b> Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>422.1</b> DUE TO <b>Arterio-sclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>Nov 10, 1958</b> , to <b>Nov 16, 1958</b> , that I last saw the deceased alive on <b>Nov 15, 1958</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <b>3308 Union Ave, Harford Grace, Md.</b>				DATE SIGNED <b>Nov 16, 1958</b>							
ACTUAL SIGNATURE <b>James W. C. Finney</b>				M.D. <b>3308 Union Ave, Harford Grace, Md.</b>				DATE SIGNED <b>Nov 16, 1958</b>				PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>Nov. 18, 1958</b>				22c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL</b>				22d. LOCATION (City, town, or county) (State) <b>HARFORD MD.</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Madison Mitchell</b>								ADDRESS <b>Harford Grace Md.</b>								24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

1900

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
JAMES J. JONES		Male		45		Jan 1, 1855		New York City		Teacher		Heart Disease		Home		10:00 AM		James J. Jones		John Doe		John Doe	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER		16. NAME OF CLERGYMAN		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF UNDERTAKER		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF INCINERATION		23. NAME OF BURIAL		24. NAME OF CREMATION	
St. John's Church		St. John's Cemetery		Rev. John Doe		Rev. John Doe		St. John's Church		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

81  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford, Grace</u>	c. LENGTH OF STAY IN 1b <u>—</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles Henry Warfield Jr.</u>	4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Proving Ground</u>	11. BIRTHPLACE (State or foreign country) <u>Perryman, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles H. Warfield Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Susie A. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War II</u>		16. SOCIAL SECURITY NO. <u>218-05-7976</u>	
17. INFORMANT <u>Mrs Katie M. Warfield</u>		Address <u>Perryman, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>REC'D Air W</u> DATE SIGNED <u>11-9-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Krawitz</u>



FOR STATE  
HEALTH DEPT.

12551

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampden Trace</u>	c. LENGTH OF STAY IN lb <u>X</u> <u>5</u> <u>Supper</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clayton Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1 Clayton Road</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Lee</u> Middle <u>Watson</u> Last	4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 July 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL INDUSTRY</u>	11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William S. Watson</u>	
14. MOTHER'S MAIDEN NAME <u>Connie YARBOROUGH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES 1924-1925</u>	
16. SOCIAL SECURITY NO. <u>216-10-3154</u>		17. INFORMANT <u>MYRTLE WATSON</u> Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arteriosclerosis C V disease</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>11-2-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDEN</u>	22d. LOCATION (City, town, or county) (State) <u>BEL AIR, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kline</u>





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12565

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellaire</u>		c. LENGTH OF STAY IN 1b <u>60 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bellaire</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>23 Lee St</u>	
d. NAME OF DECEASED (Type or print) <u>John Watters</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Watters</u>		4. DATE OF DEATH <u>November 13 1958</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 3-1881</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>John Watters</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mountain Harford Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Mountain Harford Md</u>		12. CITIZEN OF WHAT COUNTRY <u>MJ</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-20-0332</u>	
17. INFORMANT <u>Mrs Mary E Witherspoon</u>		Address <u>23 Lee St Bellaire Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bellaire, Md</u> DATE SIGNED <u>11-13-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 17-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Johns Creek Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Bellaire Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
ADDRESS <u>Bellaire Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

FOR STATE  
HEALTH DEPT

12325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

12325

1. Name of Deceased: WILLIAM J. BROWN

2. Date of Death: 11-15-58

3. Place of Death: Home

4. Age: 65 Sex: M

5. Race: W Religion: C

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Report: 11-15-58

10. District: 1

11. County: Baltimore

12. State: Md.

3 1 8  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12566

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Delaware</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NS Route 40</u>		d. STREET ADDRESS <u>517 Mary St.,</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>White</u> Last	4. DATE OF DEATH <u>November 26</u> 19 <u>58</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1925</u>
		9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Work</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claude White</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
		17. INFORMANT <u>Augusta Waller, 115 Youngs Ave, Woodlyn, Pa.,</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-26-58</u> Hour <u>11</u> a.m. <u>11</u> p.m.	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NS Route 40</u>	20f. (City or town) <u>Toppa</u> (County) <u>Hartford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11-27-58 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Delair, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Nov. 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laws Funeral Home</u>	22d. LOCATION (City, town, or county) <u>Chester, Delaware, Penna.,</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McEwen Jr</u> ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR <u>DATE DEC 1 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CLAYLAND STATE INSTITUTE OF HEALTH-BALTIMORE, MD

Delaware

517 Mary St.

Nov. 31, 1958

Virginia

Food work

Laborer

Claude White

Mary Carter

Augusta Waller, 115 Youngs Ave., Norfolk, Va.

U.S.A.

Removal Nov. 7, 1958 Laws Funeral Home

Bolington, Maryland.

Chester, Delaware, Tenn.